CITY OF SAN ANTONIO **Reasonable Accommodation Request**

SECTION I. TO BE COMPLETED BY DISABLED APPLICANT, EMPLOYEE, OR EMPLOYEE'S IMMEDIATE SUPERVISOR	
Applicant/Employee First Name & Initial:	Applicant/Employee Last Name:
Position Title:	Department:
Supervisor's Name (City employees only):	Supervisor's Title:
Office Street Address:	Telephone Number: ( )
Office City/State: /	Office Zip Code:
Describe disabling condition:	
Type of accommodation needed/requested:	
Justification:	
Medical Documentation Attached? ☐ Yes ☐ No ☐ Non-applicable	
Request Initiated by: ☐ Applicant ☐ Employee ☐ Immediate Supervisor	
Signature of Applicant/Employee:	Date:
Signature of Immediate Supervisor (if applicable)	Date:
SECTION II. TO BE COMPLETED BY CITY PHYSICIAN (if applicable)	
Referred through Human Resources Department to City Physician? ☐ Yes ☐ No ☐ Non-applicable	
City Physician Decision: ☐ Agree with type of accommodation requested ☐ Disagree with type of accommodation needed and recommends following alternate accommodation: _____ _____	
Signature of City Physician:	Date:
SECTION III. TO BE COMPLETED BY DIRECTOR OF EMPLOYING DEPARTMENT	
Recommend approval of: ☐ Accommodation requested by applicant/employee/employee's supervisor ☐ Alternate Accommodation (provide justification below) ☐ Do not recommend approval of accommodation because provision of the proposed accommodation would create an undue hardship (provide justification below)	
Justification: _____ _____ _____	
Date on which applicant/employee was advised of final decision: ____ / _____/ _____	
Signature of Director of Employing Department:	Date: